1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8574 55

CERTIFICATE OF DEATH

08571

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Cumberland
d. STREET ADDRESS: 123 Roberts St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

62

3. NAME OF DECEASED (Type or print): First: Frances — Middle: Rose — Last: Abe

4. DATE OF DEATH: Month: August — Day: 5 — Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 29, 1884

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

I

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Alonzo Ogden

14. MOTHER'S MAIDEN NAME: Ida Skinner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Evelyn Cavey — Address: 123 Roberts St., Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

592X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Chronic Nephritis with Uremia — ?

DUE TO (c): Hypertension — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Myocardial Fibrosis, Aortitis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 21, 1958, to August 5, 1958 that I last saw the deceased alive on August 5, 1958, and that death occurred at 11:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Samuel M. Jacobson M.D. — ADDRESS (Street, city or town, state): 50 Pershing Street — DATE SIGNED: 6/6/58

PHYSICIAN'S NAME (Type): Samuel M. Jacobson, M.D. — Cumberland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/8/58

22c. NAME OF CEMETERY OR CREMATORY: Abe Cemetery

22d. LOCATION (City, town, or county) (State): Near Ridgeley, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George — ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: AUG 11 '58

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A154(4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8575 — 08572 Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME BM 2/57

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 50 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 211 N. Mechanic Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 211 N. Mechanic St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RUE — Middle HERBERT — Last ALLEN

4. DATE OF DEATH: Month Aug. — Day 7, — Year 19 58

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Feb. 11, 1889
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman
10b. KIND OF BUSINESS OR INDUSTRY: Brewery
11. BIRTHPLACE (State or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW 1
16. SOCIAL SECURITY NO.: 214 05 4956
17. INFORMANT: Louis W. Allen — Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b): Coronary Selerosis —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Benedict SKITARELIC
DATE SIGNED: Aug. 7, 1958

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/9/1958
22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight — ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: AUG 11 '58
24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8659 — Reg. Dist. No. 08573

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Barton
c. LENGTH OF STAY IN 1b: 33 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Barton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma — Middle: Roberta — Last: Ashby

4. DATE OF DEATH: Month: Aug — Day: 6 — Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 19, 1879

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Dawson

14. MOTHER'S MAIDEN NAME: Eliza Major

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Curtiss Griffith-Barton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 8 Months
151X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 10, 1958, to Aug 6, 1958, that I last saw the deceased alive on Aug 6, 1958, and that death occurred at 1:15 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul R Wilson M.D. — ADDRESS (Street, city or town, state): 111 Ashfield St Piedmont, W.Va. — DATE SIGNED: 8-8-58

PHYSICIAN'S NAME (Type): Paul R. Wilson M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/9/58
22c. NAME OF CEMETERY OR CREMATORY: Meadow Point
22d. LOCATION (City, town, or county) (State): Keyser W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: E. L. Beal — ADDRESS: Westernport, Md.

24a. REC'D BY REGISTRAR — DATE: AUG 12 1958

24b. REGISTRAR'S SIGNATURE: Arthur L. Draney

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8576 — Reg. Dist. No. 08574

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 21 DAYS
d. NAME OF HOSPITAL OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 FROSTBURG
d. STREET ADDRESS: 18 GRANT STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle H. — Last BOLDEN
4. DATE OF DEATH: Month AUGUST — Day 29 — Year 1958

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DECEMBER 10
9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY: Machine Operator
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: CHARLES L. BOLDEN
14. MOTHER'S MAIDEN NAME: CHRISTINE DEGELTREE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 214-32-3073
17. INFORMANT: MEMORIAL HOSPITAL — Address: WARWICK & MEMORIAL AVENUE CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Prostate — INTERVAL BETWEEN ONSET AND DEATH: about 3 years.
177X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ no

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour o. m. p. m.; 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5-11-, 1956, to 8-29-, 1958, that I last saw the deceased alive on 8-22-, 1958, and that death occurred at 4:15 A.M. from the causes and on the date stated above.
ACTUAL SIGNATURE: Howard L. Tolson M.D. — ADDRESS (Street, city or town, state): Cumberland, Md. — DATE SIGNED: 8-29-58
PHYSICIAN'S NAME (Type): DR. H. TOLSON

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/31/58
22c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park, Frostburg
22d. LOCATION (City, town, or county) (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Bernard H. Montemurri — ADDRESS: Hafer Funeral Home 23 E. Main, Frostburg, Md.
24a. REC'D BY REGISTRAR — DATE: SEP 4 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Kuns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Carcinoma of Prostate

about 3 years

Arteriosclerosis

5-11-58 8-29-58

8-22-58

Howard ... Cumberland, Md 8-29-58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 FilmG233 9-2-58 et

8577

CERTIFICATE OF DEATH

Reg. Dist. No. 08575

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 27 DAYS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BARTON
d. STREET ADDRESS: ROUTE #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First CATHERINE Middle H. Lost BROADWATER

4. DATE OF DEATH: Month AUGUST Day 21 Year 1958

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEBRUARY 6,

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LEVI BITTINGER

14. MOTHER'S MAIDEN NAME: REBECCA BROADWATER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.
334X
DUE TO
(b): Renal Arteriosclerosis — 3 yrs.
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse lost. 260X
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Gangrene left foot - Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 24, 19 58, to 8/21, 19 58, that I last saw the deceased alive on 8/21/58, 19, and that death occurred at 11:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): 59 Bedford ST Cumberland Md
DATE SIGNED: 8/22/58

PHYSICIAN'S NAME (Type): DR. S. WEISMAN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/24/58
22c. NAME OF CEMETERY OR CREMATORY: Mt. View
22d. LOCATION (City, town, or county) (State): Moscow Md.

23. FUNERAL DIRECTOR'S SIGNATURE: E L Bowers
ADDRESS: Westernport, Md.

24a. REC'D BY REGISTRAR DATE: AUG 28 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8578 — 08576 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND,
c. LENGTH OF STAY IN 1b: 15 HOURS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: BALTIMORE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BALTIMORE 3V01-4
d. STREET ADDRESS: 1323 W. 42nd Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RACHEL Middle C Last BROWN
4. DATE OF DEATH: Month AUGUST Day 9, Year 1958.

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JANUARY 13 1879
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Ownhome
11. BIRTHPLACE (State or foreign country): MARYLAND Carroll Co.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: ISAAC STONESIFER
14. MOTHER'S MAIDEN NAME: Martha LIPPEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Weeks
420.1
DUE TO
(b): Myocarditis — 2 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 4, 1958 to Aug 9, 1958, that I last saw the deceased alive on Aug 9, 1958, and that death occurred at 7:45 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: Clay E Durrett M.D. ADDRESS (Street, city or town, state): Cumberland Md DATE SIGNED: Aug 11 58
PHYSICIAN'S NAME (Type): DR. CLAY E. DURRETT

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-13-58
22c. NAME OF CEMETERY OR CREMATORY: Lorraine Park
22d. LOCATION (City, town, or county) (State): Baltimore Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarpelli Cumberland, Md.
James F Scarpelli
24a. REC'D BY REGISTRAR DATE: AUG 12 1958
24b. REGISTRAR'S SIGNATURE: Arthur J Rooney

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8650

CERTIFICATE OF DEATH

08577

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 60 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 234 E. Main

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Frostburg
d. STREET ADDRESS: 234 E. Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alexander; Middle: ; Last: Close

4. DATE OF DEATH: Month: 8; Day: 16; Year: 1958

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 2-21-1881

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mines

11. BIRTHPLACE (State or foreign country): Eckhart, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Close

14. MOTHER'S MAIDEN NAME: Margaret Dudley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 213-05-7118

17. INFORMANT: Mrs. Alexander Close, 234 E. Main, Address Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 14 days
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 2, 1958 to Aug 16, 1958, that I last saw the deceased alive on Aug 13, 1958, and that death occurred at 10:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W O McLane M.D. — ADDRESS (Street, city or town, state): Frostburg Md. — DATE SIGNED: Aug 16 1958

PHYSICIAN'S NAME (Type): W O McLane M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-18-58

22c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park

22d. LOCATION (City, town, or county) (State): Frostburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Burial H. Montevent — ADDRESS: Hafer Funeral Home, 23 E. Main, Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: AUG 21 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8660 — Reg. Dist. No. 08578

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eckhart
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Eckhart
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: Joseph — Last: Condry

4. DATE OF DEATH: Month: 8 — Day: 2 — Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-10-1904

9. AGE (In years last birthday): 54 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Kelley Tire Co,

11. BIRTHPLACE (State or foreign country): Eckhart, Md.

12. CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: William Condry

14. MOTHER'S MAIDEN NAME: Mollie Hershberger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-01-3726

17. INFORMANT — Address: Mrs. T. Jos. Condry, Eckhart, Md. (Wife)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lupus erythematosus — INTERVAL BETWEEN ONSET AND DEATH: 3-4 years,
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

705.4

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-1, 1955, to 8-2, 1958, that I last saw the deceased alive on 8-2, 1958, and that death occurred at 10 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: H. C. Diehl, M.D. — ADDRESS (Street, city or town, state): 39 W. Main St — DATE SIGNED: 8/4/58

PHYSICIAN'S NAME (Type): H. C. Diehl, M.D. — Frostburg, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-4-1958

22c. NAME OF CEMETERY OR CREMATORY: Eckhart Cemetery

22d. LOCATION (City, town, or county) (State): Eckhart Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond H. Martingly — ADDRESS: Hafer Funeral Home, Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: AUG 6 '58

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
8M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8579 — 08579 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 75 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 516 Maryland Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 516 Maryland Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BERTHA — Middle — Last COPELAND
4. DATE OF DEATH: Month Aug. — Day 6, — Year 19 58

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 16, 1872
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: J. W. Copeland
14. MOTHER'S MAIDEN NAME: Rebecca Myers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Miss Abbie Copeland — Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Diffuse carcinomatosis	3 yrs.
DUE TO (b)	Carcinoma of breast	3 yrs.
DUE TO (c)		

170 × Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED
EXAMINER'S NAME (Type): Benedict Skitarelic — Aug. 6, 1958

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/9/1958
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight — ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR — DATE: AUG 11 '58
24b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8580

CERTIFICATE OF DEATH

08580 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 531 Cumberland, St.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland,
d. STREET ADDRESS: 531 Cumberland St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marietta Middle: Lost: Coulehan

4. DATE OF DEATH: Month: August Day: 5, Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Marxh 13, 1871

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Buffalo, N. Y.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: George Banks

14. MOTHER'S MAIDEN NAME: Mary Argus

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Mr. Joseph M. Couleham Woodlawn, La Vale, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis with
DUE TO
(b): generalized Arteriosclerosis
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 10 yrs / 1 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1945 to August 5 1958 that I last saw the deceased alive on July 28, 1958, and that death occurred at 9:00A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James T. Johnson Jr. M.D. ADDRESS (Street, city or town, state): 16 Greene St Cumberland Md DATE SIGNED: 8-7-58

PHYSICIAN'S NAME (Type): James T. Johnson Jr. M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/8/58

22c. NAME OF CEMETERY OR CREMATORY: S. S. Peter & Paul's

22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George ADDRESS: Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: AUG 11 '58

24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8581 Reg. Dist. No. 08581

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL—WARWICK AND MEMORIAL AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 19 MARION STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LLOYD Middle EDGAR Last DEAHL

4. DATE OF DEATH: Month AUGUST Day 18 Year 19 58

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 30 1907

9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman-B &O Railroad

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JOHN DEAHL

14. MOTHER'S MAIDEN NAME: BERTHA LININGER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-07-0953

17. INFORMANT: MEMORIAL HOSPITAL Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 31 HRS.
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertensive Cardiovascular Disease — 3 yrs
DUE TO
(c): Arteriosclerotic Heart Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug., 19 58, to Aug., 19 58 that I last saw the deceased alive on Aug. 17 19 58, and that death occurred at 7:00A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): 133 Va Ave, Cumberland, Md DATE SIGNED: 8/18/58

PHYSICIAN'S NAME (Type): DR. O. G. HIMMELWRIGHT

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/20/58
22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
22d. LOCATION (City, town, or county) (State): Cumberland Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Ruth E. Silcox Cumberland Maryland

24a. REC'D BY REGISTRAR DATE: AUG 20 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8582

CERTIFICATE OF DEATH

Reg. Dist. No. 08582

M

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 1/25/54
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 43 Westernport
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

91

3. NAME OF DECEASED (Type or print): First: Julia — Middle: May — Last: Derham

4. DATE OF DEATH: Month: August — Day: 17, — Year: 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/13/1884

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Westernport, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

I

13. FATHER'S NAME: John Nelson Derham

14. MOTHER'S MAIDEN NAME: Mary Catherine Ross

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: P.O.Box 599 Address: Cumberland, Md.
Allegany County Infirmary Records

0

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: ?

592 x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cerebral Arteriosclerosis — ?

DUE TO (c): Chronic Nephritis — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Paralysis Agitans.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/25/54, 19___, to 8/17/58, 19___, that I last saw the deceased alive on 8/16/58, 19___, and that death occurred at 1:15 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. McLean M.D. — ADDRESS (Street, city or town, state): 49 Greene St. — DATE SIGNED: 8/18/58

PHYSICIAN'S NAME (Type): Dr. James E. McLean — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8/20/58

22c. NAME OF CEMETERY OR CREMATORY: Philos

22d. LOCATION (City, town, or county) (State): Westernport Md.

23. FUNERAL DIRECTOR'S SIGNATURE: E. L. Bowl — ADDRESS: Westernport, Md.

24a. REC'D BY REGISTRAR DATE: AUG 20 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8583 (Reg. Dist. No.) 08583

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL WARWICK AND MEMORIAL AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 30 ROBERTS St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PEARL Middle E. Last DIVELBLISS

4. DATE OF DEATH: Month AUGUST Day 18 Year 19 58

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: AUGUST 20, 1919

9. AGE (In years last birthday): 38 yrs. IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: CHARLES RICE

14. MOTHER'S MAIDEN NAME: SARAH JOHNSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): N/O (If yes, give war or dates of service): ___

16. SOCIAL SECURITY NO.: ___

17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Status Epilepticus
353.2
DUE TO
(b): ___
DUE TO
(c): ___

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 4 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug, 19 58, to Aug, 19 58, that I last saw the deceased alive on Aug 17, 19 58, and that death occurred at 4:23A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [redacted] M.D. ADDRESS (Street, city or town, state): 133 Va Ave, Cumberland, Md DATE SIGNED: 8/18/58

PHYSICIAN'S NAME (Type): DR. O. G. HIMMELWRIGHT

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug 20, 1958

22c. NAME OF CEMETERY OR CREMATORY: Davis Memo. Park.

22d. LOCATION (City, town, or county) (State): Cumberland Md

23. FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc. ADDRESS: Cumb. Md

24a. REC'D BY REGISTRAR DATE: AUG 21 '58

24b. REGISTRAR'S SIGNATURE: Clarence E. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8584

CERTIFICATE OF DEATH

08584
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL—WARWICK AND MEMORIAL AVES.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WEST VIRGINIA
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GORMANIA 85x-3
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

M

60

3. NAME OF DECEASED (Type or print): First FRANCES Middle V. Last DULING

4. DATE OF DEATH: Month AUGUST Day 11 Year 1958

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DECEMBER 27, 1886
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY: U. S.A.

I

13. FATHER'S NAME: D. F. KERLIN
14. MOTHER'S MAIDEN NAME: ANNA BOWMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: ---
17. INFORMANT: MEMORIAL HOSPITAL Address: CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive arteriosclerotic — INTERVAL BETWEEN ONSET AND DEATH
443x
DUE TO
(b): Cardio vascular disease (Uremia)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-8- 1958 to 8-11- 1958 that I last saw the deceased alive on 8-11- 1958, and that death occurred at 5:45P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm. F. Williams M.D. ADDRESS (Street, city or town, state): Cumberland Md DATE SIGNED: 8-12-58

PHYSICIAN'S NAME (Type): DR. W. F. WILLIAMS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug 14 58.
22c. NAME OF CEMETERY OR CREMATORY: Bayard Cemetery
22d. LOCATION (City, town, or county) (State): Bayard W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: H. Creighton Oakland Md.
ADDRESS
24a. REC'D BY REGISTRAR DATE: AUG 15 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8585

CERTIFICATE OF DEATH

Reg. Dist. No. 08585

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 2/15/1873
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 406 Baltimore Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Sarah Middle B. Last Eyler

4. DATE OF DEATH: Month August Day 27, Year 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2/15/1873
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Chambersburg, Pa.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Addison H. Eyler
14. MOTHER'S MAIDEN NAME: Sarah B. Wolfe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: P.O.Box 599 Address: Cumberland, Md.
Allegany County Infirmary Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Chronic Myocardial Degeneration	?
DUE TO (b)	Cerebral Arteriosclerosis	?
DUE TO (c)	Chronic Nephritis	?

592 x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senile Deterioration

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/10/58, 19____, to 8/27/58, 19____, that I last saw the deceased alive on 8/27/58, 19____, and that death occurred at 9:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. McLean M.D. ADDRESS (Street, city or town, state): 49 Greene St. DATE SIGNED: 8/28/58

PHYSICIAN'S NAME (Type): Dr. James E. McLean Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/30/58
22c. NAME OF CEMETERY OR CREMATORY: Zion Memo. Park
22d. LOCATION (City, town, or county) (State): Cumb. Md

23. FUNERAL DIRECTOR'S SIGNATURE: Lewis Stein Inc. ADDRESS: Cumb. Md.
24a. REC'D BY REGISTRAR DATE: SEP 2 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Traum

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8586 — 08586 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 110 Seymour St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Thomas — Middle W — Last Fahey

4. DATE OF DEATH: Month August — Day 14 — Year 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 4, 1875

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Martinsburg, W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas W. Fahey

14. MOTHER'S MAIDEN NAME: Bridget McGinnis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 705-09-9975

17. INFORMANT: Richard E. Fahey, Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hemothorax, right — Interval between onset and death: 6 days

825 ×

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Crushed chest — 6 days

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Automobile accident

20c. TIME OF INJURY Month, Day, Year: 6:00 ~~A.M.~~ P.M. Aug. 6 1958

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 28 near Ridgeley, W.Va.

20f. (City or town) Near Ridgeley (County) Mineral (State) W.Va.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: August 14, 1958

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-18-1958

22c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: James F. Scarpelli, Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: AUG 18 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8651

08587 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 14 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miner's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Frostburg
d. STREET ADDRESS: 73 W. Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Isabelle; Middle: ; Last: Feidt

4. DATE OF DEATH: Month: August; Day: 18th; Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 21st, 1870

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own housework

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Findlay

14. MOTHER'S MAIDEN NAME: Rose Ann Read

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Mrs. Anna Shea, 73 W. Main St., F'bg., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertension Cardio —

DUE TO (c): Vascular disease. — 10 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m.; Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-15, 1954 to 8-18, 1958, that I last saw the deceased alive on 8-18, 1958, and that death occurred at 11:45 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: H. C. Diehl, M.D. ADDRESS (Street, city or town, state): 39 W. Main St. DATE SIGNED: 8/18/58

PHYSICIAN'S NAME (Type): H. C. DIEHL, M.D. Frostburg, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-20-58

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Altoona, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: J. R. Durst, ADDRESS: Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: AUG 21 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

M

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2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8587

08588 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 53 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 126 Columbia St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLOTTE Middle B. Last GARDNER

4. DATE OF DEATH: Month Aug. Day 18 Year 19 58

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 26, 1871

9. AGE (In years last birthday): 86 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Medical Doctor

10b. KIND OF BUSINESS OR INDUSTRY: Medicine

11. BIRTHPLACE (State or foreign country): Penna

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Gardner

14. MOTHER'S MAIDEN NAME: Charlotte Marboury

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: James Gardner Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 Mo.

904.0 ✓

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Vascular Disease

DUE TO (c): Fractured left hip — 44 Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell and fractured hip at home

20c. TIME OF INJURY: Hour 5:00 p. m. Month, Day, Year July 5 19 58

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Cumberland, Alleg. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: August 18, 1958

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 20, 1958

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: AUG 20 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8588

CERTIFICATE OF DEATH

Reg. Dist. No. 68582

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 711 MONTGOMERY AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MYRTLE M. Middle Lost GARRETT

4. DATE OF DEATH: Month AUGUST Day 25 Year 19 58

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: APRIL 8, 1889
9. AGE (In years last birthday): 69 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): MARYLAND-Cumberland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN HECK
14. MOTHER'S MAIDEN NAME: ELIZABETH LOGUE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-32-8210
17. INFORMANT: Address: MEMORIAL HOSPITAL-MEMORIAL & WARWICK AVES.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive Cerebral Hemorrhage — Interval between onset and death: 24 hrs
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertension — 8 yrs.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 24, 19 58 to Aug 25, 19 58, that I last saw the deceased alive on Aug. 24, 19 58, and that death occurred at 2:50 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Clay S Durrett M.D. ADDRESS (Street, city or town, state): Cumberland Md DATE SIGNED: 8/26/58

PHYSICIAN'S NAME (Type): DR. CLAY DURRETT

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 27, 1958
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: James F. Scarpelli ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: AUG 28 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8589 **CERTIFICATE OF DEATH** Reg. Dist. No. 08590

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b: 17 hrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 541 Henderson Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Rose — Middle — Last Gerdeman
4. DATE OF DEATH: Month August — Day 8, — Year 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7/2/1882
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Dennis Cavanaugh
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Henry A. Gerdeman — Address: Cumberland Pt's Chart. 541 Henderson ave. md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute pancreatitis	1 day
DUE TO (b)	Chronic pancreatitis	6 months
DUE TO (c)		

587.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-7-, 1958, to 8-8, 1958, that I last saw the deceased alive on 8-7-, 1958, and that death occurred at 3:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. Rinn M.D. ADDRESS (Street, city or town, state): 57 Green St, DATE SIGNED:

PHYSICIAN'S NAME (Type): Cumberland Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug 11, 1958
22c. NAME OF CEMETERY OR CREMATORY: St. Patrick's Cemetary
22d. LOCATION (City, town, or county) (State): Cumberland md.

23. FUNERAL DIRECTOR'S SIGNATURE: Lowes Stein, Ind. ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: AUG 11 '58
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08591

CERTIFICATE OF DEATH

8652 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 49 Linden St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Frostburg
d. STREET ADDRESS: 1 49 Linden St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ANNA — Middle MARGARET — Last GLORIOUS

4. DATE OF DEATH: Month August — Day 5, — Year 19 58

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-13-1928

9. AGE (In years last birthday): 30 yrs.

IF UNDER 1 YEAR: Months | Days — IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): invalid

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Glorious

14. MOTHER'S MAIDEN NAME: Josephine Dailey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Wm. Glorious, Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Metastatic Sarcoma — INTERVAL BETWEEN ONSET AND DEATH: 2 years
199.1
DUE TO (b): Sarcoma rt shoulder
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/1, 19 56, to 8/5, 19 58, that I last saw the deceased alive on 8/7, 19 58, and that death occurred at 11 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Hilda J. Walters M.D. — ADDRESS (Street, city or town, state): Broadway, Frostburg, Md. — DATE SIGNED: 8/7/58

PHYSICIAN'S NAME (Type): Hilda J. Walters, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Aug. 8 '58 — 22c. NAME OF CEMETERY OR CREMATORY: St. Michaels Cemetery — 22d. LOCATION (City, town, or county) (State): Frostburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J. R. Durst, Frostburg, Md.

24a. REC'D BY REGISTRAR — DATE: AUG 11 '58 — 24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08592

8590

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 4 DAYS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 FROSTBURG

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL
d. STREET ADDRESS: 39 N. WATER ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSEPH — Middle — Last GRECO

4. DATE OF DEATH: Month AUGUST — Day 3, — Year 1958

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: SEP.T 12, 1875
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-Miner
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): ITALY
12. CITIZEN OF WHAT COUNTRY? ITALY

13. FATHER'S NAME: FRANK GRECO
14. MOTHER'S MAIDEN NAME: MATHILDA OTT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214-01-3581
17. INFORMANT — Address: Frank Greco, 39 N. Water St., F'burg., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Vascular Dis. (Uremia) — INTERVAL BETWEEN ONSET AND DEATH: 6 Mos
DUE TO
422.1
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Degenerative Arthritis Left Knee
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS/UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-18-, 1958, to 8-3-, 1958, that I last saw the deceased alive on 8-2-, 1958, and that death occurred at 10:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. F. Williams M.D. ADDRESS (Street, city or town, state): Cumberland Md DATE SIGNED: 8-4-58

PHYSICIAN'S NAME (Type): DR. W. F. WILLIAMS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-6-58
22c. NAME OF CEMETERY OR CREMATORY: St. Michael's Cemetery,
22d. LOCATION (City, town, or county) (State): Frostburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Dent
ADDRESS:
24a. REC'D BY REGISTRAR DATE: AUG 6 '58
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8591

08593

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 4 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 427 Henderson Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 427 Henderson Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KATHERINE Middle — Last GRIMES

4. DATE OF DEATH: Month August Day 4 Year 19 58

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 14, 1875

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Andrew H. Heller

14. MOTHER'S MAIDEN NAME: Elizabeth Heyer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Chas. Grimes, 108 Oak St., Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b): Coronary Sclerosis — —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — Month, Day, Year — o. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: August 5, 1958

EXAMINER'S NAME (Type): Benedict Skitarelic M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 7, 1958

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR — DATE: AUG 11 '58

24b. REGISTRAR'S SIGNATURE: [illegible]

VS. A1SME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8592

CERTIFICATE OF DEATH

08594
Reg. Dist. No.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

1. PLACE OF DEATH a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 4HR. 5 MIN.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WEST VIRGINIA b. COUNTY: HAMPSHIRE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROMNEY 85x-3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First KATE Middle M. Last HARMISON

4. DATE OF DEATH: Month AUGUST Day 30 Year 1958

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: DECEMBER 27

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN D. MILLAR

14. MOTHER'S MAIDEN NAME: NANCY SHEETZ

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT (Address): WARWICK & MEMORIAL AVE. MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Terminal Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 48 hours

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive Cardiovascular disease ?

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from 29 aug., 1958, to 30 aug., 1958, that I last saw the deceased alive on 29 aug., 1958, and that death occurred at 3:15 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Alfred Van Ormer M.D. ADDRESS (Street, city or town, state): 172 S. Centre St. DATE SIGNED: 30 aug. 58

PHYSICIAN'S NAME (Type): DR. W. A. VAN ORMER Cumberland, Md

22a. BURIAL, ~~CREMATION~~, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 1, 1958

22c. NAME OF CEMETERY OR CREMATORY: Indian Mound

22d. LOCATION (City, town, or county) (State): Romney W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Keith Sheffler ADDRESS: Romney W. Va.

24a. REC'D BY REGISTRAR DATE: SEP 8 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kuns

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08595

CERTIFICATE OF DEATH

8593

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 7/25/58
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X La Vale
d. STREET ADDRESS: 12 Walker Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: B. — Last: Harris

4. DATE OF DEATH: Month: August — Day: 4, — Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11/18/1874

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Coal Miner

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Scotland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Harris

14. MOTHER'S MAIDEN NAME: Margaret Beverige

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): N

16. SOCIAL SECURITY NO.: None

17. INFORMANT: P.O.Box 599 Address: Cumberland, Md.
Allegany County Infirmary Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Hypostasis — INTERVAL BETWEEN ONSET AND DEATH: 18 hrs
4222
DUE TO (b): Chronic Myocarditis — ?
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (c): Cerebral Arteriosclerosis — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile deterioration.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/25/58, 19____, to 8/4/58, 19____, that I last saw the deceased alive on 8/2/58, 19____, and that death occurred at 3:55A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. McLean, M.D. — ADDRESS (Street, city or town, state): 49 Greene St. — DATE SIGNED: 8/4/58

PHYSICIAN'S NAME (Type): Dr. James E. McLean — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 6, 1958
22c. NAME OF CEMETERY OR CREMATORY: West Newton Cemetery
22d. LOCATION (City, town, or county) (State): West Newton, Pennsylvania

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: AUG 11 '58

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1 Dr. Durrett

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08596

8594 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 2 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 11 Race Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 11 Race Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Cecelia — Middle: A. — Last: Hart

4. DATE OF DEATH: Month: August — Day: 25 — Year: 19 58

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 13, 1883

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ~~Peter~~ Peter F. Hart

14. MOTHER'S MAIDEN NAME: Eva Nies

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Paul Yarnall, 11 Race St. Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Short
DUE TO (b): Myocardits & Decompensation — Hours
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. / Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1955, 19____, to Aug. 25, 1958 that I last saw the deceased alive on Aug. 1, 1958, and that death occurred at 7:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Clay E. Durrett M.D. — ADDRESS (Street, city or town, state): Cumberland Md. — DATE SIGNED: 8/26/58

PHYSICIAN'S NAME (Type): Clay E. Durrett M.D. 236 Virginia Avenue Cumberland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 28, 1958

22c. NAME OF CEMETERY OR CREMATORY: St. Peters & Pauls Cem.

22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: AUG 29 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08597

8595 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 5 Weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crump Nursing Home, 761 Fayette St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 134 Seymour Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle L Last HEINRICH

4. DATE OF DEATH: Month August Day 3 Year 1958

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 19, 1869
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: N & G Tinplate
11. BIRTHPLACE (State or foreign country): Oldtown, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Henry Heinrich
14. MOTHER'S MAIDEN NAME: Margaret Schilling

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Donald Heinrich — Address: 410 Pulaski Street, Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocarditis & Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
DUE TO
(b): Arteriosclerosis. — 10 yrs
DUE TO
(c):

422.1

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 19 55 to Aug 3, 19 58 that I last saw the deceased alive on July 25, 19 58, and that death occurred at 4:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Clay E Durett M.D.
ADDRESS (Street, city or town, state): Cumberland Md
DATE SIGNED: Aug 6, 1958

PHYSICIAN'S NAME (Type): Clay E. Durett M.D. 236 Va. Ave., Cumberland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 6, 1958
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: AUG 11 '58
24b. REGISTRAR'S SIGNATURE: W. Heinrich

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8596 **CERTIFICATE OF DEATH** Reg. Dist. No. 08598

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 8/8/53
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Savage

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany County Infirmary
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edna Middle: M. Last: Hice
4. DATE OF DEATH: Month: August Day: 13, Year: 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/21/1883
9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland, Mt. Savage
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Charles R. Uhl
14. MOTHER'S MAIDEN NAME: Alice Holtzman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: None
17. INFORMANT: P.O.Box 599 Address: Cumberland, Md.
Allegany County Infirmary Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pulmonary Hypostasis.	48 hrs.
422.1 DUE TO		
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. (b)	Chronic Myocarditis	?
DUE TO (c)	Senile Arteriosclerosis	?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile psychosis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/8/53, 19____, to 8/13/58, 19____, that I last saw the deceased alive on 8/13/58, 19____, and that death occurred at 8:45 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. McLean M.D. ADDRESS (Street, city or town, state): 49 Green St. DATE SIGNED: 8/14/58

PHYSICIAN'S NAME (Type): Dr. James E. McLean Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	8/16/58	Mt. Savage Meth. Cem.	Mt. Savage, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland
24a. REC'D BY REGISTRAR DATE: AUG 19 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8597 **CERTIFICATE OF DEATH** 08599

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 204 E. Laing Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank — Middle: P. — Last: Horwath

4. DATE OF DEATH: Month: August — Day: 16 — Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/6/88

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Window Washer

10b. KIND OF BUSINESS OR INDUSTRY: Self Employed

11. BIRTHPLACE (State or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Michael Horwath

14. MOTHER'S MAIDEN NAME: Machalino Blakawski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 217-10-1425

17. INFORMANT (Address): Patient's Chart.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 18 mon
151X
DUE TO
(b): Carcinomatosis — 3 mon
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 20, 19 58 to Aug. 16, 19 58, that I last saw the deceased alive on Aug. 15, 19 58, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Clay Durrett M.D. — ADDRESS (Street, city or town, state): Cumberland, Md. — DATE SIGNED: 8/16/58

PHYSICIAN'S NAME (Type): Dr. Clay Durrett

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 8-19-1958 — 22c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery — 22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: James F. Scarpelli, Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: AUG 19 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8598

08690 Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page [redacted] may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rt. # 6 Cumberland,
d. STREET ADDRESS: Locust Grove
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Wesley — Last: Huff

4. DATE OF DEATH: Month: August — Day: 6 — Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: June 9, 1897

9. AGE (In years last birthday): 61 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintainance work,

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11. BIRTHPLACE (State or foreign country): Rawlings, Md.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Leonard W. Huff

14. MOTHER'S MAIDEN NAME: Mary Susan Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-10-4504

17. INFORMANT: Mrs. Beulah I. Huff Address: Rt. # 6 Cumberland, Md. (wife)

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Shock — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs.
802 X
DUE TO (b): Loss of blood, severe trauma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Ran over by Railroad Locomotive

20c. TIME OF INJURY Month, Day, Year: Hour [illegible] p.m. Aug. 5, 58

20d. INJURY OCCURRED White at work ☐ Not white at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Railroad Track

20f. (City or town) (County) (State): Locust Grove. Alleg. Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: August 6, 1958
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 8, 1958

22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: H. Wayne George Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: AUG 11 '58

24b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8599

08601

Reg. Dist. No.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

1. PLACE OF DEATH a. COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland c. LENGTH OF STAY IN 1b: 5 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hosptial	d. STREET ADDRESS: 1 141 Reynolds Street e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Emma	T.	Humphreys	August	27	19 58

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W.		2/26/1873	85 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jospeh Stevens	Francis Garner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	None	Chart

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition, extreme — INTERVAL BETWEEN ONSET AND DEATH: 6 Months

171x

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Carcinoma of the Cervix, Grade IV — 10 Months

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 20th, 1958, to August 27th, 1958, that I last saw the deceased alive on August 26th, 1958, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Doerner Jr. M.D. — ADDRESS (Street, city or town, state): Algonquin Hotel, Cumberland, Md. — DATE SIGNED: 8-27-58

PHYSICIAN'S NAME (Type): Dr. W. Doerner, M.D. — Algonquin Hotel

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Aug 28, 1958	Odd Fellows Cemetery	Flintstone Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
John J. Hafer	Cumberland Md.	AUG 29 58	Arthur S. Travis

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8600

08602

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 34 HOURS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X LA VALE
d. STREET ADDRESS: 19 OAKLAWN AVE.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BABY Middle GIRL Last IRONS

4. DATE OF DEATH: Month AUGUST Day 7 Year 1958.

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUGUST 6, 1958.

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months Days 1
IF UNDER 24 HRS.: Hours 10 Min. 23

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: CLAUDE IRONS

14. MOTHER'S MAIDEN NAME: KATHLEEN F. HOSMER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MEMORIAL HOSPITAL - Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity
DUE TO (b): Hyaline Membrane
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. DUE TO (c): 773.5

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-6, 1958 to 8-7, 1958, that I last saw the deceased alive on 8-7, 1958, and that death occurred at 5:35 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. R. Hodges M.D.
ADDRESS (Street, city or town, state): Cumberland, Md
DATE SIGNED: 8/9/58.

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/14/58
22c. NAME OF CEMETERY OR CREMATORY: RoseHill Cemetery
22d. LOCATION (City, town, or county) (State): Smethport, Pa

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Ruth E. Silcox Cumberland Maryland

24a. REC'D BY REGISTRAR DATE: AUG 12 1958
24b. REGISTRAR'S SIGNATURE: Arthur L. Kenny

2060233XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8653 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

08603 Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 3 ds
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Westernport
d. STREET ADDRESS: R.D. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mildred — Middle: Betty — Last: Jose

4. DATE OF DEATH: Month: Aug — Day: 26 — Year: 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 24. 1927
9. AGE (In years last birthday): 30 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Brashear
14. MOTHER'S MAIDEN NAME: Erma Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mr. Wayne Brashear-Westernport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Crushed Chest - Atelectasis Lungs — INTERVAL BETWEEN ONSET AND DEATH: 40½ Hrs
825X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b): Ruptured Spleen - Ruptured Liver
DUE TO (c): Retro Peritoneal Hematoma

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture Left Forearm. Fracture Rt 1st Toe

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Automobile Accident
20c. TIME OF INJURY Month, Day, Year — Hour: 5:30 p.m. Aug 24 1958
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town) (County) (State): near Lonaconing Allegany Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W. O. McLane M.D.
EXAMINER'S NAME (Type): W. O McLane MD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Aug 26 1958

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 28, 58
22c. NAME OF CEMETERY OR CREMATORY: Miller Cem.
22d. LOCATION (City, town, or county) (State): Allegany Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C S Beal
ADDRESS: Westernport, Md.
24a. REC'D BY REGISTRAR — DATE: AUG 28 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08604

8601 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 43 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WARWICK AND MEMORIAL HOSPITAL—MEMORIAL AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 126 SPRINGDALE STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

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60

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3. NAME OF DECEASED (Type or print): First: LIZZIE — Middle: MAY — Last: KLINGER

4. DATE OF DEATH: Month: AUGUST — Day: 4 — Year: 19 58

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: APRIL 3, 1884

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): INDIANA -RICHMOND

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

I

13. FATHER'S NAME: JAMES XXX YUTZ

14. MOTHER'S MAIDEN NAME: LUCY GRIMSLEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Uraemia — INTERVAL BETWEEN ONSET AND DEATH: 4 wks

174X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Adeno-Carcinoma of Uterus

DUE TO (c): ? Carcinomatosis — 5 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

0

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 25, 1958, to Aug. 4, 1958, that I last saw the deceased alive on Aug. 4, 1958, and that death occurred at 7:15 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Clay E. Durrett M.D. — ADDRESS (Street, city or town, state): Cumberland Md — DATE SIGNED: 8/5/58

1

PHYSICIAN'S NAME (Type): DR. CLAY E. DURRETT

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-7-1958

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli, Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: AUG 7 '58

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08605

8602

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 8/21/58
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Lonaconing
d. STREET ADDRESS: 23 Church Hill St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Maria — Middle: — Last: Lamb

4. DATE OF DEATH: Month: August — Day: 26, — Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8/25/1871

9. AGE (In years last birthday): 87 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lonaconing, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Humphery

14. MOTHER'S MAIDEN NAME: Isabel Clarkson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: P.O.Box 599 — Address: Cumberland, Md.
Allegany County Infirmary Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: ?
592X
DUE TO (b): Cerebral Arteriosclerosis — ?
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (c): Chronic Nephritis — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Ascites

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/21/58, 19____, to 8/26/58, 19____, that I last saw the deceased alive on 8/25/58, 19____, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. McLean M.D. — ADDRESS (Street, city or town, state): 49 Greene St. — DATE SIGNED: 8/26/58

PHYSICIAN'S NAME (Type): Dr. James E. McLean — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 8/28/1958 — 22c. NAME OF CEMETERY OR CREMATORY: Memorial Park — 22d. LOCATION (City, town, or county) (State): Frostburg, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: GEORGE EICHHORN — ADDRESS: LONACONING, MD.

24a. REC'D BY REGISTRAR DATE: AUG 28 '58

24b. REGISTRAR'S SIGNATURE: Clifford L. Mraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8603 **CERTIFICATE OF DEATH**

08606
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 30 DAYS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART HOSPITAL
d. STREET ADDRESS: 1 300 OLDTOWN ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First REV. Middle P. Last LANDRIGAN
4. DATE OF DEATH: Month AUGUST Day 17 Year 1958

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1/12/1889
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PRIEST -PASTOR
10b. KIND OF BUSINESS OR INDUSTRY: Catholic Church
11. BIRTHPLACE (State or foreign country): MASS. (EVERETT)
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Montague Landrigan
14. MOTHER'S MAIDEN NAME: Mary Murphy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 215-36-9398
17. INFORMANT: PATIENTS CHART Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Cardiac Vascular Disease — 5 yrs

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Uremia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 13 July, 1958, to 17 Aug, 1958, that I last saw the deceased alive on 17 Aug, 1958, and that death occurred at 5:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James G Stegmaier M.D.
ADDRESS (Street, city or town, state): 122 S. Centre St., Cumberland, Md.
DATE SIGNED:

PHYSICIAN'S NAME (Type): J. G. Stegmaier, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-21-58
22c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarpelli, Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: AUG 19 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08607

8604

CERTIFICATE OF DEATH

Reg. Dist. No.

M

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 2 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND

62

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART HOSPITAL
d. STREET ADDRESS: 438 WALNUT ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNABELL; Middle; Last LANGE

4. DATE OF DEATH: Month AUGUST; Day 29; Year 19 58

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: AUG. 8, 1901
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

I

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: JOHN MANUEL
14. MOTHER'S MAIDEN NAME: CHARLOTTE KLINE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: PT'S CHART — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Acute Myocardial Infarction 7 days
DUE TO
(c) Arteriosclerotic Heart Disease — 2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Obesity — Gall bladder disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

0

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m.; Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 27, 19 58, to Aug 29, 19 58, that I last saw the deceased alive on Aug 28, 19 58, and that death occurred at 2 10 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A Bereaman MD — M.D.
ADDRESS (Street, city or town, state): 59 Greene St
DATE SIGNED: August 30, 1958

PHYSICIAN'S NAME (Type): S. G. WEISMAN M. D. — Cumberland Maryland

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 1, 1958
22c. NAME OF CEMETERY OR CREMATORY: Rosehill Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: John J. Hafer, Cumberland, Maryland.
24a. REC'D BY REGISTRAR DATE: SEP 3 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 4 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8661 Item 9 FilmG232 8-13-58 et

08608 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Lonaconing
d. STREET ADDRESS: Railroad Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: DAVID — Middle: — Last: LAUDER

4. DATE OF DEATH: Month: Aug — Day: 5th. — Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept, 21. 1899

9. AGE (In years last birthday): 59 58 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Automobile Mechanic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Nikep, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David Lauder

14. MOTHER'S MAIDEN NAME: Mary Eilbeck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 220-10-4528

17. INFORMANT: Miss Agnes Lauder, Lonaconing, MD. (SISTER)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b): Coronary Sclerosis — —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: Aug 5, 1958
EXAMINER'S NAME (Type): Benedict Skitarelic

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/7/1958
22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial
22d. LOCATION (City, town, or county) (State): Cumberland, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: George Eichhorn
ADDRESS: Lonaconing, MD.

24a. REC'D BY REGISTRAR DATE: AUG 8 '58
24b. REGISTRAR'S SIGNATURE: [illegible]

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08609

8654 Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 4 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miner's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Route 1, Frostburg
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eugene — Middle: — Last: Layman

4. DATE OF DEATH: Month: Aug — Day: 30 — Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: August 24th, 1875

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John N. Layman

14. MOTHER'S MAIDEN NAME: Anna R. Fazenbaker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mrs. Doris Stonebraker, Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 4 Days
DUE TO
903.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Fracture Left Femur — 3 Days
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell in back yard at his home

20c. TIME OF INJURY — Hour: 900 a.m. ~~p.m.~~ — Month, Day, Year: Aug 26 1958

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): His yard

20f. (City or town) Frostburg (County) Allegany (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W O McLane M.D.
EXAMINER'S NAME (Type): W O McLANE MD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Sept 1 1958

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-2-58
22c. NAME OF CEMETERY OR CREMATORY: F'burg. Memorial Park
22d. LOCATION (City, town, or county) Frostburg, (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Joseph R. Durst, Frostburg, Md.

24a. REC'D BY REGISTRAR — DATE: SEP 3 '58

24b. REGISTRAR'S SIGNATURE: Clifton L. Evans

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8605

CERTIFICATE OF DEATH

08610

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 7 3/4 HRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 47 THOMAS STREET,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BABY — Middle: GIRL — Last: LEPLEY

4. DATE OF DEATH: Month: AUGUST — Day: 2, — Year: 19 58.

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUGUST 2, 1958.

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 7 Min.: 45

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: PAUL V. LEPLEY

14. MOTHER'S MAIDEN NAME: DELORES J. NORRIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Anoxia — INTERVAL BETWEEN ONSET AND DEATH
762.5
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Atelectasis
DUE TO
(c): Prematurity

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Travis Powell M.D.

ADDRESS (Street, city or town, state)

DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 8/13/58

22c. NAME OF CEMETERY OR CREMATORY: Memorial Hospital

22d. LOCATION (City, town, or county) (State): Cumberland Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR DATE: AUG 8 '58

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After [illegible] certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

2060246XVI

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08611

8655

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 24 W. College Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Frostburg
d. STREET ADDRESS: 1 24 W. College Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ELIZA — Middle (SEMLER) — Last LEWIS

4. DATE OF DEATH: Month August — Day 25, — Year 19 58

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 25, 1883

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Semler

14. MOTHER'S MAIDEN NAME: Virginia Conner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-34-4919

17. INFORMANT: Walter Hunter, Address: Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
Hypertension
(c)

INTERVAL BETWEEN ONSET AND DEATH
2wk
8 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
260X
Diabetes

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1950, 19__ to Aug 25, 1958, that I last saw the deceased alive on Aug 24, 1958, and that death occurred at 2:12 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm C Lane M.D.
ADDRESS (Street, city or town, state): E. Main St., Frostburg, Md.
DATE SIGNED: Aug 25 1958

PHYSICIAN'S NAME (Type): W. O. McLane, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-27-58
22c. NAME OF CEMETERY OR CREMATORY: F'bg. Memorial Park
22d. LOCATION (City, town, or county) (State): Frostburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. R. Durst, ADDRESS: Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: AUG 28 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Kime

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08612

CERTIFICATE OF DEATH

8656 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 12 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Eckhart
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle Last LEWIS

4. DATE OF DEATH: Month AUGUST Day 16, Year 19 58

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-20-1876

9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Owen Lewis

14. MOTHER'S MAIDEN NAME: Elizabeth Porter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT Address: Mrs. Edward Carter, Eckhart, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intestinal Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 4 Days
DUE TO
570.5
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: Cause undetermined
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 13, 19 58 to Aug 16, 1958, that I last saw the deceased alive on Aug 13, 19 58, and that death occurred at 6:32 A M from the causes and on the date stated above.

ACTUAL SIGNATURE: W. O. McLane M.D. ADDRESS (Street, city or town, state): E. Main St., Frostburg, Md. DATE SIGNED: Aug 16 1958

PHYSICIAN'S NAME (Type): W. O. McLane, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-18-1958

22c. NAME OF CEMETERY OR CREMATORY: Eckhart Cemetery

22d. LOCATION (City, town, or county) (State): Eckhart, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J. R. Durst, Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: AUG 19 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Wiatt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08613

8606 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 20 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 328 EMILY STREET

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 328 EMILY STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
MOLLIE	REBECCA	LIPSCOMB	AUGUST	1,	1958

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W		JULY 14, 1870	88 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	OWN HOME	HERRING, WEST VIRGINIA	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
BENJAMIN V. MC MILLAN	CASSIE GREENLEAF

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	NONE	MRS. WAYNE LIPSCOMB, CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO
(b): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from 8/ /, 1958, to 8/ /, 1958, that I last saw the deceased alive on 8/ /, 1958, and that death occurred at 1:00 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Leo H. Ley, Jr. M.D. — ADDRESS (Street, city or town, state): 456 N. Centre St., Cumberland, Md. — DATE SIGNED: 8/4/58

PHYSICIAN'S NAME (Type): LEO H. LEY Jr., M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	AUG. 4, 1958	McNEELY CEMETERY	HENDRICKS, WEST VIRGINIA

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
JOHN J. HAFER, CUMBERLAND, MARYLAND	AUG 5 '58	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8657

CERTIFICATE OF DEATH

08614

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 4yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 30 Stoyer

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: 30 Stoyer
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John — Middle E. — Last Long

4. DATE OF DEATH: Month 8 — Day 9 — Year 1958

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: I0 27 I867

9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Tin Mill

11. BIRTHPLACE (State or foreign country): Cumberland Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Long

14. MOTHER'S MAIDEN NAME: Sarah Stafford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Frostburg, Md. — Mrs. Ethel Harden, 30 Stoyer St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma right ear — INTERVAL BETWEEN ONSET AND DEATH: 2 years.
DUE TO
(b): c metastasis to brain.
DUE TO
(c): Senility.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

199.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour ____ o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-15, 19 57, to 8-9, 19 58, that I last saw the deceased alive on 8-9, 19 58, and that death occurred at 4 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H. C. Diehl, M.D.
ADDRESS (Street, city or town, state): 39 W. Main St.
DATE SIGNED: 8/10/58

PHYSICIAN'S NAME (Type): H. C. Diehl, M.D. Frostburg, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-I2-I958
22c. NAME OF CEMETERY OR CREMATORY: Hyndman Cemetery
22d. LOCATION (City, town, or county) (State): Hyndman Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: P. H. Mottingly
ADDRESS: Hafer Funeral Home, Frostburg, Md.

24a. RECD BY REGISTRAR DATE: AUG 14 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kunes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08615

CERTIFICATE OF DEATH

8607 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL, MEMORIAL AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 1109 VIRGINIA AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MRS. Middle MOLLIE CATHERINE Last LONG

4. DATE OF DEATH: Month AUG. Day 25 Year 19 58

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: OCT. 21, 1866
9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA-Altoona
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JAMES WESTBROOK
14. MOTHER'S MAIDEN NAME: SUSAN KESSER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Arteriosclerotic Cardiovascular 442X	
DUE TO (b)	Renal disease - with hypertension	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Cardiac decompensation & Cardiac failure	5 yrs +

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Thrombotic vascular lesions hemorrhoidal veins with bleeding

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 20, 19 58, to Aug 25, 19 58, that I last saw the deceased alive on Aug 25, 19 58, and that death occurred at 7:56 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wyhe M Faw Jr M.D.
ADDRESS (Street, city or town, state): Cumberland md
DATE SIGNED: Aug 25 58
PHYSICIAN'S NAME (Type): 1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 28, 1958
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: James F, Scarpelli
ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: AUG 28 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8608

CERTIFICATE OF DEATH

Reg. Dist. No. 08616

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 13 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELLERSLIE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First LUCINDA — Middle — Last LOWERY

4. DATE OF DEATH: Month AUGUST — Day 26 — Year 19 58

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: OCTOBER 29, 1878

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EMANUEL A. LOWERY

14. MOTHER'S MAIDEN NAME: SARA WITT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: WARWICK & MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Massive Pulmonary Embol. — INTERVAL BETWEEN ONSET AND DEATH: Immed.
570.5

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Gall stone obstr. of ileum — 1 wk before op
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Uremia post-op (oper Aug 1 '58)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 13, 1958 to Aug 26, 1956 that I last saw the deceased alive on 8-26-58, 19____, and that death occurred at 11:30PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: A.J. Mirkin M.D.
ADDRESS (Street, city or town, state): 145 So. Centre St. Cumberland Md.
DATE SIGNED:

PHYSICIAN'S NAME (Type): DR. A.J. MIRKIN

22a. BURIAL, CREMATION, REMOVAL, (Specify): Burial
22b. DATE THEREOF: 8-31-58
22c. NAME OF CEMETERY OR CREMATORY: Pala Alto Cemetery
22d. LOCATION (City, town, or county) (State): Eyedman R.D.1 Pa

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Murphy Funeral Home Eyedman, Pa

24a. REC'D BY REGISTRAR DATE: SEP 3 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08617

8609

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oldtown Maryland
d. STREET ADDRESS: Oldtown Md.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: Luteman — Last:
4. DATE OF DEATH: Month: Aug — Day: 27 — Year: 1958

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Sept 29, 1873
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Truck Farm.
11. BIRTHPLACE (State or foreign country): Oldtown Md
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Rudolph Luteman
14. MOTHER'S MAIDEN NAME: Evaline Twigg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs. Evelyn Myerly, Greenspring Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Embolism or rupture, Cerebral — INTERVAL BETWEEN ONSET AND DEATH: 5 days.
DUE TO
(b): Arteriosclerosis General — I0-20 yrs.
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

332 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour: o. m. / p. m. — 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-23-58, 19____, to ____, 19____, that I last saw the deceased alive on 8-23-58, 19____, and that death occurred at 11 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: J. I. Armstrong M.D. — ADDRESS (Street, city or town, state): Paw Paw, W. Va. — DATE SIGNED: 8-28-58.
PHYSICIAN'S NAME (Type): J. I. Armstrong.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/30/58
22c. NAME OF CEMETERY OR CREMATORY: Oldtown Cem.
22d. LOCATION (City, town, or county) (State): Oldtown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc — ADDRESS: Cumb. Md.
24a. REC'D BY REGISTRAR DATE: SEP 2 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

M

91

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1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8610

Reg. Dist. No. 08618

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 9/23/57
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 1 315 Pennsylvania Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ora — Middle: P. — Last: Markwood

4. DATE OF DEATH: Month: August — Day: 20, — Year: 19 58

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 3/2/1875

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own House

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: John W. Morrison

14. MOTHER'S MAIDEN NAME: Hannah Newcomb

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: P.O.Box 599 Allegany County Infirmary Records
Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral Hemorrhage.	2 wks.
DUE TO (b)	Cerebral arteriosclerosis	?
DUE TO (c)	Chronic Myocarditis	?

422.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Left Hemiplegia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/23/57, 19____, to 8/20/58, 19____, that I last saw the deceased alive on 8/20/58, 19____, and that death occurred at 3:20 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. McLean, M.D. — ADDRESS (Street, city or town, state): 49 Greene St. — DATE SIGNED: 8/20/58

PHYSICIAN'S NAME (Type): Dr. James E. McLean — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug 22 1958

22c. NAME OF CEMETERY OR CREMATORY: Burlington Cemetery

22d. LOCATION (City, town, or county) (State): Burlington, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: William A Light — ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: AUG 22 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8611

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08619

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): 1604 Frederick St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 XXXX Cumberland
d. STREET ADDRESS: 1604 Frederick St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DAVID — Middle WILLIAM — Last MASON

4. DATE OF DEATH: Month Aug. — Day 16, — Year 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 15, 1880

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Grocery

11. BIRTHPLACE (State or foreign country): St. George, W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Mason

14. MOTHER'S MAIDEN NAME: Isabella Close

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): Spanish Am.

16. SOCIAL SECURITY NO.: 214-05-4351

17. INFORMANT — Address: Donald W. Mason -- Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

4.20.1

DUE TO (b): Coronary Sclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: August 17, 1958

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/19/1958

22c. NAME OF CEMETERY OR CREMATORY: HillCrest Burial Park

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George — ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR — DATE: AUG 20 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8612 — Reg. Dist. No. — 08620

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Bow Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 267 Williams St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Arch — Middle: — Last: Mathews

4. DATE OF DEATH: Month: August — Day: 12 — Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 15, 1897

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: House painting

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles H. Mathews

14. MOTHER'S MAIDEN NAME: Mary Martz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 220 26 7609

17. INFORMANT: Ruth Mathews — Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Abdominal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs.
45/x
DUE TO (b): Rupture of Arteriosclerotic Aortic Aneurysm..
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: August 12, 1958
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/14/1958
22c. NAME OF CEMETERY OR CREMATORY: St. Peter & Pauls Cem.
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight — ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: AUG 14 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 [illegible] be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 [illegible] the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08621

CERTIFICATE OF DEATH

8613 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 6/12/58
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 1 608 Hill Top Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alfred — Middle: — Last: McKenzie

4. DATE OF DEATH: Month: August — Day: 4, — Year: 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9/30/1875

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - B&O R. R. Conductor

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Moses McKenzie

14. MOTHER'S MAIDEN NAME: Mary Brewer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 705-12-3717

17. INFORMANT: P.O.Box 599 Address: Cumberland, Md.
Allegany County Infirmary Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Hypostasis — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
DUE TO (b): Chronic Hypertrophic Cardiitis — ?
DUE TO (c): Cerebral Arteriosclerosis — ?

422.2

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senile deterioration

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20b. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/12/58, 19____, to 8/4/58, 19____, that I last saw the deceased alive on 8/4/58, 19____, and that death occurred at 3:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. McLean M.D. — ADDRESS (Street, city or town, state): 49 Greene St. — DATE SIGNED: 8/5/58

PHYSICIAN'S NAME (Type): Dr. James E. McLean — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 7, 1958

22c. NAME OF CEMETERY OR CREMATORY: HILLCREST BURIAL PARK

22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: AUG 11 '58

24b. REGISTRAR'S SIGNATURE: W. Resch

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1 4

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8614 — Reg. Dist. No. 08622

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: West Virginia b. COUNTY: Mineral
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R.D. #1 Ridgely, West Virginia
d. STREET ADDRESS: 85 X 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Charles Edward — Middle: — Last: Messick

4. DATE OF DEATH: Month: August — Day: 23 — Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 15, 1932

9. AGE (In years last birthday): 25 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Food Products

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Charles Messick

14. MOTHER'S MAIDEN NAME: Hazel White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1950-1953

16. SOCIAL SECURITY NO.: 232 48 1743

17. INFORMANT — Address: Mrs. Dorothy Messick-Rt. 1, Ridgely, W. Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemothorax — INTERVAL BETWEEN ONSET AND DEATH: 20 Minutes
DUE TO
825X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Crushed Chest
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Ruptured Liver

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Automobile Accident

20c. TIME OF INJURY — Hour: 1:30 P.M. — Month, Day, Year: Aug. 23 1958

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street

20f. (City or town) (County) (State): Near Ridgely, Mineral, W.Va.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: August 23, 1958

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug 25, 1958
22c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John J. Hafer, Cumberland, Md.

24a. REC'D BY REGISTRAR — DATE: AUG 27 '58
24b. REGISTRAR'S SIGNATURE: Clarence E. Howard

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 4 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8615 — Reg. Dist. No. — 08623

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WARWICK-MEMORIAL MEMORIAL HOSPITAL-AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BARTON
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MARGARET Middle M. Last METZ

4. DATE OF DEATH: Month AUGUST Day 4 Year 1958

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 3

9. AGE (In years last birthday): 61 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): BARTON, MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: OATHE INSKEEP

14. MOTHER'S MAIDEN NAME: SARAH RUSSELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MEMORIAL HOSPITAL Address: CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Cervix uteri - Extensive — INTERVAL BETWEEN ONSET AND DEATH: 3+ years

171X

DUE TO (b) Ureteral Obstruction with Uremia — 6 months

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

DUE TO (c) Carcinoma

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1955 to Aug 4, 1958, that I last saw the deceased alive on Aug 4, 1958, and that death occurred at 3:10P M. from the causes and on the date stated above.

ACTUAL SIGNATURE: W M Faw Jr M.D. — ADDRESS (Street, city or town, state): Cumberland md — DATE SIGNED: Aug 5, 1958

PHYSICIAN'S NAME (Type): DR. WYLIE FAW

22a. BURIAL, CREMATION, REMOVAL (Specify): Buried — 22b. DATE THEREOF: 8/7/58 — 22c. NAME OF CEMETERY OR CREMATORY: Samuel Hill — 22d. LOCATION (City, town, or county) (State): Moscow Md

23. FUNERAL DIRECTOR'S SIGNATURE: E. J. Boal - Westernport — ADDRESS

24a. REC'D BY REGISTRAR DATE AUG 11 '58 — 24b. REGISTRAR'S SIGNATURE: Audrey Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8616

CERTIFICATE OF DEATH

08624
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 40 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 524 Columbia Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 524 Columbia Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Bernetta Middle Virginia Last Miller

4. DATE OF DEATH: Month 8 Day 16 Year 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Nov. 8, 1914
9. AGE (In years last birthday): 43 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (State or foreign country): Ridgeley, W. Va.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Wilson
14. MOTHER'S MAIDEN NAME: Eva B. See

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-10-4151
17. INFORMANT: Mrs. Eva B. See, Cumberland, Md. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CARCINOMA CERVIX — INTERVAL BETWEEN ONSET AND DEATH: 5 YRS.
171X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JULY, 1958 to AUG., 1958, that I last saw the deceased alive on AUG. 11, 1958, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank T. Cawley M.D.
ADDRESS (Street, city or town, state): MEMORIAL HOSP. CUMBERLAND MD.
DATE SIGNED: 8-18-58
PHYSICIAN'S NAME (Type): Dr. Frank T. Cawley

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-21-1958
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarpelli, Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: AUG 19 '58
24b. REGISTRAR'S SIGNATURE: Evelyn L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 233 8-27-58 et

08625

CERTIFICATE OF DEATH

8658 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allrgany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Lonaconing
d. STREET ADDRESS: High Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

61

3. NAME OF DECEASED (Type or print): First MATTHEW Middle Last MUIR

4. DATE OF DEATH: Month AUGUST Day 14 Year 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: NOV, 16th. 1887

9. AGE (In years last birthday): 71 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Night Watchman V.F.W. Club

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lonaconing MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Muir

14. MOTHER'S MAIDEN NAME: Elizabeth Robertson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-05-5737

17. INFORMANT: Mrs. Emma Muir (WIFE) Address: Lonsconing, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchogenic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
162.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 13, 1958 to Aug 14, 1958 that I lost saw the deceased alive on Aug 14, 1958, and that death occurred at 4 a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Leslie R. Miles Jr. M.D.
ADDRESS (Street, city or town, state): Lonaconing Md
DATE SIGNED: Aug 15, 1958

PHYSICIAN'S NAME (Type): LESLIE R. MILES SR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/16/1958
22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
22d. LOCATION (City, town, or county) (State): Cumberland, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: GEORGE EICHHORN
ADDRESS: LONACONING, MD.

24a. REC'D BY REGISTRAR DATE: AUG 18 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the case as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08626

Item 9 Film G232 8-18-58 et

CERTIFICATE OF DEATH

8617 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND,
c. LENGTH OF STAY IN 1b: 56 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 1 INDEPENDENCE ST. EXT.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First SADIE — Middle ROSE — Last MULLAN

4. DATE OF DEATH: Month AUGUST — Day 8, — Year 19 58.

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 5, 1877

9. AGE (In years last birthday): 81 82 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: WILLIAM MULLAN

14. MOTHER'S MAIDEN NAME: ANNA CARLOS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Terminal Broncho Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
170x
DUE TO
(b): Carcinomatosis of Spine, Lung — 1 yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Carcinoma of Right Breast — 3 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis Diabetes

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19 58, to Aug 8, 19 58, that I last saw the deceased alive on Aug 8, 19 58, and that death occurred at 4:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A. Weisman M.D. — ADDRESS (Street, city or town, state): 54 Greene St Cumberland, Md. — DATE SIGNED: 8/9/58

PHYSICIAN'S NAME (Type): DR. S. G. WEISMAN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Aug. 11, 1958 — 22c. NAME OF CEMETERY OR CREMATORY: St. Peter & Pauls Cem. — 22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight — ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: AUG 12 1958 — 24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08627

8618

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 1021 Harding Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ellis; Middle: Ray; Last: Northcraft

4. DATE OF DEATH: Month: August; Day: 15; Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/7/88

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Baktender

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Patrick Northcraft

14. MOTHER'S MAIDEN NAME: Ann Gordon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-05-8017

17. INFORMANT: Patient's chart. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 week
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Heart Disease — 4 yrs
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchial Asthma

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour o. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1958, to August 1, 1958, that I last saw the deceased alive on July 31, 1958, and that death occurred at 11:18 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wilma P. James M.D. — ADDRESS (Street, city or town, state): 441 N. Centre St — DATE SIGNED: 8/18/58

PHYSICIAN'S NAME (Type): William P. James, M.D. — Cumberland, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug 18, 1958
22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Cem.
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John J. Hafer — ADDRESS: Cumberland Md.

24a. REC'D BY REGISTRAR: DATE AUG 19 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8619

CERTIFICATE OF DEATH

08628

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 37 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WARWICK AND MEMORIAL HOSPITAL- MEMORIAL AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 878 SPERRY TERRACE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle B. — Last ORT

4. DATE OF DEATH: Month AUGUST — Day 28 — Year 1958

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: FEBRUARY 28 1887
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: B & O Machinist
11. BIRTHPLACE (State or foreign country): FROSTBURG, MD.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: BENJAMIN ORT
14. MOTHER'S MAIDEN NAME: Helper MARGARET BRODE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 705-05-5332
17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ventricular dilatation Fatigue — myocardial — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs
523.0
DUE TO (b): Chronic Myocarditis — 1 yr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Silicosis — not known

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/6/56, 19____, to 8/29/58, 19____, that I last saw the deceased alive on 8/28/58, 19____, and that death occurred at 10:25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. J. Williams M.D. — ADDRESS (Street, city or town, state): Cumberland Md. — DATE SIGNED: 8/29/58

PHYSICIAN'S NAME (Type): DR. RICHARD J. WILLIAMS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 31.1958
22c. NAME OF CEMETERY OR CREMATORY: Frostburg Mem. Park
22d. LOCATION (City, town, or county) (State): Frostburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John J. Hafer, Cumberland, Maryland
24a. REC'D BY REGISTRAR DATE: SEP 2 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8620

08629

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 7 Bellevue Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 7 Bellevue Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: — Last: Parch

4. DATE OF DEATH: Month: August — Day: 12, — Year: 1958 19

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 15, 1889

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: K-S Tire Co.

11. BIRTHPLACE (State or foreign country): Rome, Italy

12. CITIZEN OF WHAT COUNTRY? Unknown ✓

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ~~No~~ Yes (If yes, give war or dates of service): W W I

16. SOCIAL SECURITY NO.: 217-10-6638

17. INFORMANT: Mrs. Virginia MCBee — Address: 943 Gay Street Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Gunshot wound of head — INTERVAL BETWEEN ONSET AND DEATH: Sudden

976X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Self inflicted
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Suicide

20c. TIME OF INJURY: Hour: 2:30 ~~a.m.~~ p.m. — Month, Day, Year: 8-12 1958

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Cumberland, Alleg, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: August 14, 1958

EXAMINER'S NAME (Type): Benedict Skitarelic M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 15, 1958

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: AUG 19 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

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FOR STATE HEALTH DEPT.

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2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8621 — Reg. Dist. No. 08630

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumbdrland
c. LENGTH OF STAY IN 1b: 3mos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 7 Bellevue Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 1 7 Bellevue Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET — Middle LILLIAN — Last PARCH

4. DATE OF DEATH: Month August — Day 12 — Year 19 58

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 2,1918

9. AGE (In years last birthday): 40 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Barney S. Nichols

14. MOTHER'S MAIDEN NAME: Ethel Harvey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 569-32-2090

17. INFORMANT: Mrs. Virginia McBee — Address: 943 ~~Guy~~ Street Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Crushed Skull — INTERVAL BETWEEN ONSET AND DEATH: 30 min.
DUE TO (b): Hammer blows (Homicide)
DUE TO (c):

983x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Killed by husband.

20c. TIME OF INJURY Hour a. m. ~~p. m~~ 2nd Month, Day, Year 8-12 1958

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Cumberland, Alleg, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: August 14, 1958

EXAMINER'S NAME (Type): Benedict Skitarelic M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: August 15, 1958
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Bur. Park
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John J. Hafer — ADDRESS: Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: AUG 19 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page [redacted] may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8622

CERTIFICATE OF DEATH

08631

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 2 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 913 Maryland Avenue ~~913 W. FIRST ST.~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RAYMOND Middle LEE Last PRYOR

4. DATE OF DEATH: Month AUGUST Day 18 Year 1958

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 1ST, -1887

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Mch

10b. KIND OF BUSINESS OR INDUSTRY: WM Railroad

11. BIRTHPLACE (State or foreign country): MARYLAND Cumberland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Morgan ? Pryor

14. MOTHER'S MAIDEN NAME: Hanna ? Baxter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Patient's Chart
Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Progressive Bulbar Paralysis — INTERVAL BETWEEN ONSET AND DEATH: 3 mos
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Cardio-Vasc. Disease — 2 yrs
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar. 1958 to Aug 18 1958, that I last saw the deceased alive on Aug 18, 1958, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Clay E. Durrett M.D.
ADDRESS (Street, city or town, state): Cumberland Md
DATE SIGNED: Aug 19, 1958

PHYSICIAN'S NAME (Type): Clay E. Durrett M.D.
Va. Avenue, Cumberland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 19, 1958
22c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Park
22d. LOCATION (City, town, or county) (State): Allegany County, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: AUG 21 '58

24b. REGISTRAR'S SIGNATURE: Anthony J. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8623

CERTIFICATE OF DEATH

08632

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): CUMBERLAND
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION: SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 208 PIEDMONT AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BENNO — Middle — Last RAPP

4. DATE OF DEATH: Month AUGUST — Day 10 — Year 1958

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-20-1895

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Broker

10b. KIND OF BUSINESS OR INDUSTRY: Insurance

11. BIRTHPLACE (State or foreign country): GERMANY, Frankfurt

12. CITIZEN OF WHAT COUNTRY? U. S. A,

13. FATHER'S NAME: MORITZ RAPP (DECEASED)

14. MOTHER'S MAIDEN NAME: EMMA BERBERICH (DECEASED)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Mr. Norman Kline 208 Piedmont Ave., Cumberland, Md.

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute coronary occlusion	1 hour
DUE TO		
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last. (b)	Arteriosclerotic heart disease	1 Year
DUE TO (c)	generalized arteriosclerosis	1 year

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cancer of stomach with liver metastases

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-4, 1958, to 8-10, 1958, that I last saw the deceased alive on 8-10, 1958, and that death occurred at 5:45 ☒ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. Brings M.D. — ADDRESS (Street, city or town, state): 57 Greene St. — DATE SIGNED: 8-11-58

PHYSICIAN'S NAME (Type): Lewis Brings M.D. — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 11, 1958

22c. NAME OF CEMETERY OR CREMATORY: East View Cemetery

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Charles L. George, Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: AUG 13 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG2339-2-58 et

8624

CERTIFICATE OF DEATH

08633

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: Dead on arrival
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 1500 Hilltop Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

60

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Elizabeth — Last: Reed

4. DATE OF DEATH: Month: Aug. — Day: 7 — Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 11, 1885

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

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13. FATHER'S NAME: John W. Walsh

14. MOTHER'S MAIDEN NAME: Annie E. Messman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Robert W. Reed — Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Short
DUE TO (b): Hypertension — 5 yrs
DUE TO (c): Obesity — 10 yrs

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

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20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 4, 1958, to Aug. 7, 1958, that I last saw the deceased alive on Aug. 4, 1958, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Clay E. Smith M.D. — ADDRESS (Street, city or town, state): Cumberland Md — DATE SIGNED: 8/9/58

PHYSICIAN'S NAME (Type): 1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug 11, 1958

22c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery

22d. LOCATION (City, town, or county) (State): Cumberland Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Louis Stein, Inc. Cumberland, Md

24a. REGISTRAR: AUG 11 1958 DATE

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08634

8625

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
o. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 44 yrs
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 306 Park Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 306 Park Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: R. — Last: Ricker

4. DATE OF DEATH: Month: August — Day: 6 — Year: 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept 14, 1880

9. AGE (In years lost birthday): 77 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired telegraph operator- W-Md

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Ambrose P. Ricker

14. MOTHER'S MAIDEN NAME: Margaret Conner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO. 705-10-7872

17. INFORMANT — Address: Mrs. Mary Ricker Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): generalized Arteriosclerosis
DUE TO
(c): Probable Coronary thrombosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

450.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1953, to 8/6, 1958, that I last saw the deceased alive on 8/6, 1958, and that death occurred at M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: George M Simons M.D. — 12 E Union St

PHYSICIAN'S NAME (Type): George M. Simons, M.D. — Cumberland Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug 9/58

22c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery

22d. LOCATION (City, town, or county) (State): Cumberland Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Ruth E. Silcox Cumberland Maryland

24a. REC'D BY REGISTRAR DATE: AUG 11 '58

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08635

8626

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 9 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL FLINTSTONE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First BLANCHE — Middle — Last ROBINETTE

4. DATE OF DEATH: Month AUGUST — Day 25 — Year 1958

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 10, 1888

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: At home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Jackson M. Ash

14. MOTHER'S MAIDEN NAME: JENNIE ASH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: PATIENTS CHART — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of vagina + labia — INTERVAL BETWEEN ONSET AND DEATH: Two months
176.8
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Hypertension with Decompensation

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19 55 to 8-25, 19 58 that I last saw the deceased alive on 8-24, 19 58, and that death occurred at 4:40A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. T. Johnson Jr. M.D. — ADDRESS (Street, city or town, state): 16 Greene St Cumberland Md — DATE SIGNED: 8-26-58

PHYSICIAN'S NAME (Type): JAMES T. JOHNSON, JR., M.D. — 16 GREENE ST., CUMBERLAND, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/27/58
22c. NAME OF CEMETERY OR CREMATORY: Odd Fellows Cemetery
22d. LOCATION (City, town, or county) (State): Flintstone Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Ruth E. Silcox Cumberland Maryland

24a. REC'D BY REGISTRAR DATE: AUG 28 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08636

8627

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 30 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 13 N. Lee Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 13 N. Lee Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ELVA Middle: C. Last: SCOTT

4. DATE OF DEATH: Month: 8 Day: 29 Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 2, 1882

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Michigan

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Scott Lantz Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis

420.1

DUE TO (b): and ventricular fibrillation

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): —

INTERVAL BETWEEN ONSET AND DEATH: died in sleep

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/21/56, 19__ to 8/25/58, 19__, that I last saw the deceased alive on 8/25/58, 19__, and that death occurred at about 1 a. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R. J. Williams M.D. ADDRESS (Street, city or town, state): 122 S/ Centre Street DATE SIGNED: August 29, 58

PHYSICIAN'S NAME (Type): Richard Jones Williams M.D. XXX Cumberland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/31/1958

22c. NAME OF CEMETERY OR CREMATORY: Hill Crest Cemetery

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: SEP 2 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After [redacted] certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached [redacted] use as the burial-transit permit. Then please remove carbon po[redacted] Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08637

8628 **CERTIFICATE OF DEATH**

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH a. COUNTY: ALLEGANY — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND — c. LENGTH OF STAY IN 1b: 27 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FLINTSTONE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART HOSPITAL	d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)	First: GEORGE	Middle: Edward	Last: SELF	4. DATE OF DEATH	Month: AUGUST	Day: 31	Year: 1958	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: 12-6-1889	9. AGE (In years last birthday): 68 yrs.	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cinder Man	10b. KIND OF BUSINESS OR INDUSTRY: B & O Railroad	11. BIRTHPLACE (State or foreign country): WEST VIRGINIA	12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: BILLY SELF		14. MOTHER'S MAIDEN NAME: CARRIE ANN MEYERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: PT'S CHART — Address	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary thrombosis with — INTERVAL BETWEEN ONSET AND DEATH: 3 months

151x

DUE TO (b): weakness to liver

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that I attended the deceased from May 1, 19 58, to Sept 1, 19 58, that I last saw the deceased alive on Sept 1, 19 58, and that death occurred at 2:15 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: B. M. Schindler M.D. — ADDRESS (Street, city or town, state): 43 Green St Cumberland, Md — DATE SIGNED: 9-1-58

PHYSICIAN'S NAME (Type): B.M.SCHINDLER M. D. — 43 GREEN ST.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: Sept 3, 1958	22c. NAME OF CEMETERY OR CREMATORY: Glendale Ch. of Brethren	22d. LOCATION (City, town, or county): Allegany Co.	(State): Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John J. Hafer, Cumberland, Md. — ADDRESS	24a. REC'D BY REGISTRAR DATE: SEP 3 '58	24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss	

1

FOR STATE HEALTH DEPT.

M

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8629

08638

Reg. Dist. No.

99

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page [illegible] may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and [illegible] with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D. O. A. Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 1 118 Seymour St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: A. — Last: Sensabaugh

4. DATE OF DEATH: Month: August — Day: 7 — Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 17, 1931

9. AGE (In years last birthday): 27 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shovel Operator

10b. KIND OF BUSINESS OR INDUSTRY: Stone quarry

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Grover A. Sensabaugh

14. MOTHER'S MAIDEN NAME: Margaret Nesbit

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): Korean

16. SOCIAL SECURITY NO.: 212-24-1405

17. INFORMANT — Address: Mr. Grover A. Sensabaugh, Cumberland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

910.3

IMMEDIATE CAUSE (a): Shock — INTERVAL BETWEEN ONSET AND DEATH: 30 Min.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Abdominal hemorrhage

DUE TO

(c) Crushing injury

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Crushed in Landslide

20c. TIME OF INJURY — Hour: 9:30 a. m. — Month, Day, Year: Aug. 7 1958

20d. INJURY OCCURRED While at work ☒ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Const. Job.

20f. (City or town) (County) (State): Near Cumberland, Alleg. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: August 7, 1958

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-II-58

22c. NAME OF CEMETERY OR CREMATORY: Sun Set Memorial Park

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli, Cumberland, Md.

James F. Scarpelli

24a. REC'D BY REGISTRAR — DATE: AUG 12 1958

24b. REGISTRAR'S SIGNATURE: Arthur Strauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08639

8630

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 8/18/56
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Frostburg
d. STREET ADDRESS: 61 Broadway Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Grace — Middle: S. — Last: Shaffer

4. DATE OF DEATH: Month: August — Day: 18, — Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/11/1872

9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-Storekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Store

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Henry B. Shaffer

14. MOTHER'S MAIDEN NAME: Elizabeth Sager

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: P.O.Box 599 Address: Cumberland, Md.
Allegany County Infirmary Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral Hemorrhage.	1 hr.
DUE TO (b)	Cerebral arteriosclerosis	?
DUE TO (c)	Chronic Myocarditis	?

422.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile deterioration.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/18/56, 19____, to 8/18/58, 19____, that I last saw the deceased alive on 8/18/58, 19____, and that death occurred at 11:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. McLean M.D. — ADDRESS (Street, city or town, state): 49 Greene St. — DATE SIGNED: 8/19/58

PHYSICIAN'S NAME (Type): Dr. James E. McLean — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-21-58

22c. NAME OF CEMETERY OR CREMATORY: F'bg. Memorial Park

22d. LOCATION (City, town, or county) (State): Frostburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Joseph R. Durst, Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: AUG 21 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08640

CERTIFICATE OF DEATH

8631 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 6 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WEST VIRGINIA b. COUNTY: HAMPSHIRE ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PAW PAW 85 X-3
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First LONEY Middle ELMER Last SHAMBAUGH
4. DATE OF DEATH: Month AUGUST Day 19 Year 19 58.
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JULY 12, 1896.
9. AGE (In years last birthday): 62 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): MAGNOLIA, W. VA.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.
13. FATHER'S NAME: ALBERT SHAMBAUGH
14. MOTHER'S MAIDEN NAME: MARY WHISNER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Arteriosclerotic Cardio-	
442X DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	vascular Renal disease. (Uremia)	4yrs
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-13-, 1958, to 8-19-, 1958, that I last saw the deceased alive on 8-19-, 1958, and that death occurred at 9:35P.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. F. Williams M.D. ADDRESS (Street, city or town, state): Cumberland Md. DATE SIGNED: 8-20-58

PHYSICIAN'S NAME (Type): DR. W. F. WILLIAMS

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: Aug. 23, 58
22c. NAME OF CEMETERY OR CREMATORY: Rose Cem.
22d. LOCATION (City, town, or county) (State): RURAL PAW PAW, W. VA.

23. FUNERAL DIRECTOR'S SIGNATURE: Parks Funeral Home, Berkeley Springs, W. Va. ADDRESS
24a. REC'D BY REGISTRAR DATE: AUG 22 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8632

CERTIFICATE OF DEATH

08641

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 41 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: PENNSYLVANIA
b. COUNTY: SOMERSET
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CONFLUENCE 75 X-3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ORPHA Middle C. Last SHIRER

4. DATE OF DEATH: Month AUGUST Day 10 Year 1958

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEB. 4, 1895

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: JOEL MILLER

14. MOTHER'S MAIDEN NAME: AMANDA DIEHL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Embolus — INTERVAL BETWEEN ONSET AND DEATH: 3 days
420.1
DUE TO (b): Auricular Fibrillation, Myocardial Fibrosis, Coronary Arteriosclerosis — 15 years
DUE TO (c): Myocardial Stenosis and Insufficiency, Aortic Stenosis and Insufficiency — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 24, 1916, to August 10, 1958, that I last saw the deceased alive on August 9, 1958, and that death occurred at 1:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): 50 Pershing Street — DATE SIGNED: 8/11/58

PHYSICIAN'S NAME (Type): DR. S. JACOBSON — Cumberland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): 8-10-58

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY: Addison Cemetery

22d. LOCATION (City, town, or county) (State): Addison Pa

23a. FUNERAL DIRECTOR'S SIGNATURE: W. B. Richenbrazer — ADDRESS: Addison Pa

24a. REC'D BY REGISTRAR DATE: 8-12-58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

8-12-58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08642

8633

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WEST VIRGINIA — b. COUNTY: HAMPSHIRE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FORT ASHBY 85 x-3
d. STREET ADDRESS: BOX 24,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: OSCAR — Middle: M. — Last: SISK

4. DATE OF DEATH: Month: AUGUST — Day: 3 — Year: 19 58.

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 8, 1903

9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Grocery & Gas Station

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JAMES W. SISK

14. MOTHER'S MAIDEN NAME: CARRIE TUCKER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 236-36-I69I

17. INFORMANT: MEMORIAL HOSPITAL - CUMBERLAND, MD.
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 10 da.
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary Heart Disease — 3 wk.
DUE TO
(c) Uremic poisoning — 10 da.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): none

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 30, 19 58, to August 3, 19 58, that I last saw the deceased alive on August 3, 19 58, and that death occurred at 3:35 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: James P. Hallinan M.D. M.D.
ADDRESS (Street, city or town, state): 140 Bedford St.
DATE SIGNED: 8-4-58

PHYSICIAN'S NAME (Type): James P. Hallinan M. D. DR. EARL R. PAUL
Cumberland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-6-58
22c. NAME OF CEMETERY OR CREMATORY: Fort Ashby Cem.
22d. LOCATION (City, town, or county) (State): Fort Ashby W.Va.

23. FUNERAL DIRECTOR'S SIGNATURE: James F. Scarpelli
ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: AUG 7 '58
24b. REGISTRAR'S SIGNATURE: W. Heuer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08643

8634

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 27 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X CRESAPTOWN
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALBERT — Middle R. — Last SMITH

4. DATE OF DEATH: Month AUGUST — Day 21 — Year 1958

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEB. 10, 1889

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: FARMER

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JAMES SMITH

14. MOTHER'S MAIDEN NAME: SARAH JAY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220 16 2692 M

17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma of the stomach — INTERVAL BETWEEN ONSET AND DEATH: 9 mo.
151X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Abdominal carcinomatosis — 6 mo.
DUE TO
(c): Cachexia — 6 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Severe anemia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): none

20c. TIME OF INJURY Hour a. m. p. m. none Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 24, 1958 to August 21, 1958, that I last saw the deceased alive on August 21, 1958, and that death occurred at 2:25 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: James F. Hallinan M.D. — M.D.
ADDRESS (Street, city or town, state): 140 Bedford Street
DATE SIGNED: 8-21-58

PHYSICIAN'S NAME (Type): DR. JAMES HALLINAN — Cumberland, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 24, 1958
22c. NAME OF CEMETERY OR CREMATORY: Fairview Christian Cem.
22d. LOCATION (City, town, or county) (State): Artemus Pa.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John J. Hafer, Cumberland, Md.

24a. REC'D BY REGISTRAR — DATE: AUG 27 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8635

CERTIFICATE OF DEATH

08644

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 17 DAYS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MC COOLE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LOY — Middle: FRANKLIN — Last: SMITH

4. DATE OF DEATH: Month: AUGUST — Day: 17 — Year: 1958

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 27, 1899

9. AGE (In years last birthday): 59 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: W.VA. PULP & PAPER MILL

11. BIRTHPLACE (State or foreign country): ROCKINGHAM, VA.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: CHARLES SMITH

14. MOTHER'S MAIDEN NAME: ANNA WHETZEL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic nephritis with terminal uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

163X

DUE TO (b): Carcinoma left lung with metastases — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): ~~Carcinoma~~

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Compression fracture 1 lumbar vertebra, approx. 1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): yes Question.

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 30 July 1958 to 17 aug 1958, that I last saw the deceased alive on 17 aug 58, 19____, and that death occurred at 3:35 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Alfred Van Ormer M.D. — ADDRESS (Street, city or town, state): 122 S Centre St. Cumberland, Md. — DATE SIGNED: 17 aug. 58

PHYSICIAN'S NAME (Type): DR. VAN ORMER

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/19/58

22c. NAME OF CEMETERY OR CREMATORY: Philos

22d. LOCATION (City, town, or county) (State): Westernport, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: E J Boal — ADDRESS: Westernport, Md.

24a. REC'D BY REGISTRAR — DATE: AUG 20 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08645

8636

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 1 424 CENTRAL AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SIMON Middle Heilman Last SNOWDEN

4. DATE OF DEATH: Month AUGUST Day 22 Year 19 58.

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: APRIL 26, 1874

9. AGE (In years last birthday) XXX 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: C & P Telephone Co

11. BIRTHPLACE (State or foreign country): PENNSYLVANIE Shellsburg

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: CHARLES SNOWDEN

14. MOTHER'S MAIDEN NAME: CORNELIA GIBNEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-03-6270

17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days
420.1
DUE TO (b): Arteriosclerotic Cardio — Many years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Vascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8:20, 1958 to 8:22, 1958, that I last saw the deceased alive on 8:22, 1958, and that death occurred at 1:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. F. Williams M.D. — ADDRESS (Street, city or town, state): Cumberland Md — DATE SIGNED: 8-25-58

PHYSICIAN'S NAME (Type): DR. W. F. WILLIAMS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/25/58

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: AUG 27 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from Pages 1 and 2 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8637

08646

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland

c. LENGTH OF STAY IN 1b: 7/31/58

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Allegany County Infirmary

d. STREET ADDRESS: 605 N. Mechanic St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Laura Middle: M. Last: Stein

4. DATE OF DEATH: Month: August Day: 7, Year: 19 58

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4/27/1870

9. AGE (In years last birthday): 88 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Henry Martz

14. MOTHER'S MAIDEN NAME: Catherine Ennis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: P.O.Box 599 Address: Cumberland, Md.
Allegany County Infirmary Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: ?

592 X

DUE TO

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

(b): Cerebral Arteriosclerosis — ?

DUE TO

(c): Chronic Nephritis — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile deterioration

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/31/58, 19____, to 8/7/58, 19____, that I last saw the deceased alive on 8/7/58, 19____, and that death occurred at 4:40 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. McLean M.D. — ADDRESS (Street, city or town, state): 49 Greene St. — DATE SIGNED: 8/8/58

PHYSICIAN'S NAME (Type): Dr. James E. McLean — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 11, 1958

22c. NAME OF CEMETERY OR CREMATORY: S.S. Peter & Paul Cemetery

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Louis Stein, Inc. — ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: AUG 11 '58

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8638

CERTIFICATE OF DEATH

08647

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 2 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 1 206½ FULTON STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

62

3. NAME OF DECEASED (Type or print): First MARY — Middle ANN — Last STRAUB
4. DATE OF DEATH: Month AUGUST — Day 17 — Year 1958

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3-3-73
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Adam P. Leonard
14. MOTHER'S MAIDEN NAME: Emma Claar

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Magdalene Bibaw — Address: Balto Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 14 days
DUE TO (b): Generalized Arteriosclerosis — ?
DUE TO (c): Arteriosclerotic Heart disease — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1953, 19—, to Aug 17, 1958, that I last saw the deceased alive on Aug 17, 1958, and that death occurred at —M, from the causes and on the date stated above.

ACTUAL SIGNATURE: George M Brown M.D. — ADDRESS (Street, city or town, state): 120 Baltimore St — DATE SIGNED: 8/18/58
PHYSICIAN'S NAME (Type): Cumberland Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/20/58
22c. NAME OF CEMETERY OR CREMATORY: St Mary's Cem
22d. LOCATION (City, town, or county) (State): Cumb. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc — ADDRESS: Cumb. Md.
24a. REC'D BY REGISTRAR DATE: AUG 21 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08648

8639 **CERTIFICATE OF DEATH** Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Lonaconing
d. STREET ADDRESS: Detmold Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Sarah; Middle; Last Summers

4. DATE OF DEATH: Month August; Day 9; Year 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 24, 1873

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Caretaker

10b. KIND OF BUSINESS OR INDUSTRY: Public School

11. BIRTHPLACE (State or foreign country): Ireland, Belfast

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Douglas

14. MOTHER'S MAIDEN NAME: Sarah Mony

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Patient's chart. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident (Embolus) — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Left Bundle Branch Block Myocardial Fibrosis?
DUE TO
(c) Coronary Arteriosclerosis ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bromidism, Uremia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour o. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 2, 1958, to August 8, 1958, that I last saw the deceased alive on August 8, 1958, and that death occurred at 4:20 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Samuel Jacobson M.D. — ADDRESS (Street, city or town, state): 50 Pershing Street — DATE SIGNED: 8/9/58

PHYSICIAN'S NAME (Type): Samuel M. Jacobson, M.D. — Cumberland, Md. — 8/9/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 11, 1958

22c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cem.

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: AUG 12 1958

24b. REGISTRAR'S SIGNATURE: Arthur L. Kruger

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8640

CERTIFICATE OF DEATH

08649

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 6 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WARWICK AND MEMORIAL HOSPITAL- MEMORIAL AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X LA VALE
d. STREET ADDRESS: 64 LA VALE COURT
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MABEL; Middle; Last TOMS

4. DATE OF DEATH: Month AUGUST; Day 15; Year 1958

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 3, 1910

9. AGE (In years last birthday): 48 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): MARYLAND Frostburg

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: WILLIAM DUGAN

14. MOTHER'S MAIDEN NAME: MAE KEEDY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Status Asthmaticus — INTERVAL BETWEEN ONSET AND DEATH: 10 days

241X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Bronchial Asthma — 2 years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6 - 10, 1957, to 8 - 15 1958 that I last saw the deceased alive on 8 - 15, 1958, and that death occurred at 10:23 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph W. Ballin, M.D. ADDRESS (Street, city or town, state): 62 Greene St. Cumberland, Md. DATE SIGNED

PHYSICIAN'S NAME (Type): DR. RALPH BALLIN — 8-16-58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/17/58

22c. NAME OF CEMETERY OR CREMATORY: Restlawn Mem. Park

22d. LOCATION (City, town, or county) (State): Allegany County, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: AUG 19 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8641 **CERTIFICATE OF DEATH** 08650

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 34 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SARRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL FLINTSTONE
d. STREET ADDRESS: Route 1,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHNNY Middle WALTER Last

4. DATE OF DEATH: Month AUGUST Day 26 Year 19 58

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 3, 1945

9. AGE (In years last birthday): 12 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): PA.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ARTHUR WALTER

14. MOTHER'S MAIDEN NAME: ORPHA KEEFER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: PATIENTS CHART

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Osteogenic Sarcoma with — INTERVAL BETWEEN ONSET AND DEATH: 6mos
196.9
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
(b) metastasis—generalized
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-24, 19 58 to 7-26, 19 58, that I last saw the deceased alive on 8-26, 19 58, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William P. James M.D. ADDRESS (Street, city or town, state): DATE SIGNED: 8-27-58

PHYSICIAN'S NAME (Type): WILLIAM P. JAMES, M.D. 141 N. CENTRE ST., CUMBERLAND, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug 29 1958

22c. NAME OF CEMETERY OR CREMATORY: Zion Cemetery

22d. LOCATION (City, town, or county) (State): Near Chaneysville Pa

23. FUNERAL DIRECTOR'S SIGNATURE: Jos. A. Knight ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: SEP 2 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08651

DRS. HODGES-MOULD

8642 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — STATE: MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 4 HRS.-51 MIN
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND,
d. STREET ADDRESS: FREDERICK ST. APT. 4-D BENJAMIN APTS.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BABY — Middle: BOY — Last: WHEELER

4. DATE OF DEATH: Month: AUGUST — Day: 5 — Year: 19 58

5. SEX: MALE

6. COLOR OR RACE: COLORED

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUGUST 5 -1958

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours: 4 — Min.: 51

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ALFRED WHEELER

14. MOTHER'S MAIDEN NAME: TAYLOR, BESSIE MAE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: MEMORIAL HOSPITAL-MEMORIAL & WARWICK AVES.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis
DUE TO
(b): Congenital Syphilis
DUE TO
(c):

762.5

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Louis Rauld M.D.
ADDRESS (Street, city or town, state): 122 So. Centre St. Cumberland, Maryland
DATE SIGNED: 5/8/58

PHYSICIAN'S NAME (Type): DRS. HODGES-MOULD

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 8/5/58
22c. NAME OF CEMETERY OR CREMATORY: Memorial Hospital
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS

24a. REC'D BY REGISTRAR — DATE: AUG 8 '58
24b. REGISTRAR'S SIGNATURE

2060409XVI

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 4 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8643 — 08652 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 50 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Potomac River

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland,
d. STREET ADDRESS: 26 Greene St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRY — Middle JOHN — Last WHITE
4. DATE OF DEATH: Month August — Day 13, — Year 19 58
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 26, 1884
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Night watchman
10b. KIND OF BUSINESS OR INDUSTRY: 2nd Nat. Bank
11. BIRTHPLACE (State or foreign country): Washington, Penna.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Homer White
14. MOTHER'S MAIDEN NAME: Angeline John

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-05-9027
17. INFORMANT: Address: Mrs. Fannie White 26 Greene St., Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 975x Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Drowning
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: B. Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): B. Skitarelic, M.D.
DATE SIGNED: August 13, 1958

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/16/58
22c. NAME OF CEMETERY OR CREMATORY: St. Luke's Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George — ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR — DATE: AUG 18 '58
24b. REGISTRAR'S SIGNATURE: Anthony L. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8644 — 08653 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 39 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WARWICK AND MEMORIAL HOSPITAL- MEMORIAL AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X MT. SAVAGE
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELIAS — Middle JAMES — Last WILLIAMS

4. DATE OF DEATH: Month AUGUST — Day 18 — Year 1958

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JANUARY 13, 1882

9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED COAL MINER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JOSIAH WILLIAMS

14. MOTHER'S MAIDEN NAME: ELIAS, MARY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-14-4058

17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 332 X Cerebral Vascular Accident "Embolus" — INTERVAL BETWEEN ONSET AND DEATH: 39 days
DUE TO
(b) Coronary Arteriosclerosis Myocardial Fibrosis — ?
DUE TO
(c) Pulmonary Emphysema with Fibrosis — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 002 X Possible Pulmonary Tuberculosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 10, 1958, to August 18, 1958, that I last saw the deceased alive on August 17, 1958, and that death occurred at 6:40A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): 50 Pershing St. — DATE SIGNED: 8/18/58

PHYSICIAN'S NAME (Type): Dr. S. M. Jacobson — Cumberland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Aug. 21, 1958 — 22c. NAME OF CEMETERY OR CREMATORY: Memorial Park — 22d. LOCATION (City, town, or county) (State): Frostburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Harvey L. Zeigler — ADDRESS: Hyndman, Pa.

24a. REC'D BY REGISTRAR DATE: AUG 22 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

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2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8645

08654 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 45yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 407 Grand Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Lloyd Middle Albert Last Winters
4. DATE OF DEATH: Month August Day 30 Year 1958

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 11, 1884
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Railway Express (clerk)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Preston County W.Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John L. Winters
14. MOTHER'S MAIDEN NAME: Maggie Snyder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 714-10-2508
17. INFORMANT: Mae Winters Address: 407 Grand Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 30 Min.

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic C V disease
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: August 30, 1958
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-I-58
22c. NAME OF CEMETERY OR CREMATORY: North Glade Cem.
22d. LOCATION (City, town, or county) (State): North Glade, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: James F. Scarpelli
ADDRESS: Cumberland, Md.
James F. Scarpelli

24a. REC'D BY REGISTRAR DATE: SEP 3 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page [illegible] may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and [illegible] with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08655

8646

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 2 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 506 Rizer Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 1 506 Rizer Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KATARZYNA — Middle — Last YACENICH

4. DATE OF DEATH: Month Aug. — Day 24, — Year 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 27, 1883

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Waysil Hnatyk

14. MOTHER'S MAIDEN NAME: Marya Tichocka

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 234 12 9741D

17. INFORMANT: Edward Yacenich — Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma Liver — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.
DUE TO
151 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Carcinoma of Stomach — 6-8 mos.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 19 58, to Aug 24, 19 58 that I last saw the deceased alive on Aug 23, 19 58, and that death occurred at 6 05 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William R James M.D. — ADDRESS (Street, city or town, state): 441 N. Centre St — DATE SIGNED: 8-26-58

PHYSICIAN'S NAME (Type): William R James — Cumberland, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-27-58
22c. NAME OF CEMETERY OR CREMATORY: Rest Lawn Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight — ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: AUG 27 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from case as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8647 — Reg. Dist. No. 08656

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 9 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL, MEMORIAL AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND, MD,
d. STREET ADDRESS: 146 BOONE ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MR. ERNEST — Middle W. — Last YATES
4. DATE OF DEATH: Month AUG. — Day 27 — Year 1958

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
M	W	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9/9 1877	80 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Receptionist	Tire Co.	VIRGINIA Luray	U.S.A.

13. FATHER'S NAME: WARFIELD YATES
14. MOTHER'S MAIDEN NAME: ANNA FRISTOE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — Address
No	2I4-05-8578	2I4-05-8578 MEMORIAL HOSPITAL, CUMBERLAND, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 45 minutes

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Coronary Sclerosis — 5 yrs

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma Prostate and Renal Metastasis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. / p. m., Month, Day, Year 19	20d. INJURY OCCURRED: While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/7/57, 19____, to 7/27/57, 19____, that I last saw the deceased alive on 7/27/57, 19____, and that death occurred at 12:20PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: R Williams M.D. — ADDRESS (Street, city or town, state): Cumberland Md — DATE SIGNED: 8/29/57

PHYSICIAN'S NAME (Type): DR, RICHARD J. WILLIAMS

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	8-30-58	Hillcrest Burial Park	Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS	24a. REC'D BY REGISTRAR — DATE	24b. REGISTRAR'S SIGNATURE
James F. Scarpelli Cumberland, Md.	SEP 2 '58	Arthur S. Kraus

James F. Scarpelli

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 1SM 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8648

CERTIFICATE OF DEATH

Reg. Dist. No. 08657

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 6 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL- WARWICK AND MEMORIAL AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X ELLERSLIE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First HATTIE — Middle V. — Last ZEIGLER

4. DATE OF DEATH: Month AUGUST — Day 16 — Year 1958

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 10, 1880

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JACOB KIMBLE Kimmel

14. MOTHER'S MAIDEN NAME: ALTFATHER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 162-16-5806B

17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypertensive Cardiovascular

442X

DUE TO (b): renal disease (uremia)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — o. m. / p. m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-10-, 1958, to 8-16-, 1958, that I last saw the deceased alive on 8-16-, 1958, and that death occurred at 8:27 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. F. Williams M.D. — ADDRESS (Street, city or town, state): Cumberland — DATE SIGNED: 8-18-58

PHYSICIAN'S NAME (Type): DR. W. F. WILLIAMS

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: Aug. 19, 1958

22c. NAME OF CEMETERY OR CREMATORY: IOOF Cemetery

22d. LOCATION (City, town, or county) (State): Stoptown Pa

23. FUNERAL DIRECTOR'S SIGNATURE: Harvey A. Zeigler — ADDRESS: Hyndman, Pa

24a. REC'D BY REGISTRAR DATE: AUG 22 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7,8 Film 0233 9-5-58 et

8649

CERTIFICATE OF DEATH

Reg. Dist. No. 08658

1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
c. LENGTH OF STAY IN 1b 5 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVE.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X ELLERSLIE
d. STREET ADDRESS 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First MR. Middle OWEN Last ZEIGLER

4. DATE OF DEATH Month AUGUST Day 27 Year 19 58

5. SEX M.

6. COLOR OR RACE W.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 3-1-83

9. AGE (In years last birthday) 75 yrs.

IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School custodian

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) BERLIN, PA.

12. CITIZEN OF WHAT COUNTRY? X U.S.A.

13. FATHER'S NAME CHARLEY ZEIGLER

14. MOTHER'S MAIDEN NAME NANCY MOSTOLLAR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 188-16-5805

17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic

422.1 DUE TO (b) Disease (Uremia)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 7

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-4-, 19 58, to 8-27-, 19 58, that I last saw the deceased alive on 8-26-, 19 58, and that death occurred at 10:05 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE W. F. Williams M.D. ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 8-27-58

PHYSICIAN'S NAME (Type) DR. W.F.WILLIAMS

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 8-30-58

22c. NAME OF CEMETERY OR CREMATORY Stoystown Cemetery

22d. LOCATION (City, town, or county) (State) Stoystown, Pa

23. FUNERAL DIRECTOR'S SIGNATURE [illegible] ADDRESS Stoystown Pa

24a. REC'D BY REGISTRAR DATE SEP 3 '58

24b. REGISTRAR'S SIGNATURE Arthur S Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55